**Maternal Record**

Name: ______________________________ Type of birth: SVD C/S Forceps Vacuum

| Date/ Time of Birth: | Allergies: | Perineum: Intact 1° 2° 3° 4° Epis |
|---|---|---|
| | Blood Group: Rh: | Medications: |
| Delivery Notes: | WinRho: _____date/time/lot#_____ | Lab Results: |

| Date | Day/Loc. | Vital Signs | Breasts/ Nipples | Fundus | Lochia | Bowel/ Bladder | Peri./ Incision | Mood/ Activities |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**Narrative:**______________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Final Visit:** Date:_________________________

Breasts: ______________________________________ Lochia: ______________________________________________

PAP done: ☐ Yes ☐ No Due:_______________ Pelvic exam / Perineum: ________________________________

Contraception: ________________________________ Debrief: ______________________________________________

Mood/ General Well-Being: ______________________________________________________________________

Peri-conceptual counselling/ Referrals:________________________________________________________